December 17, 2002

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

TECHNICAL CORRECTIONS TO UNION-SPONSORED CAPE/BLUE SHIELD MEDICAL PLAN

Joint Recommendation With Director Of Personnel That Your Board:

1. Approve corrected California Association of Professional Employees (CAPE)/Blue Shield plan changes and approve proposed rates and benefit coverages for the period January 1, 2003 to December 31, 2003, as shown on Exhibit I.

PURPOSE OF RECOMMENDED ACTION

The purpose of the recommendation is to implement technical corrections to the CAPE health plan as requested by CAPE.

JUSTIFICATION

The changes are requested by CAPE and are necessary to maintain medical plan coverage for out-of-state CAPE/Blue Shield subscribers.

Implementation of Strategic Plan Goals

The recommendations are consistent with the principles of the Countywide Strategic plan to promote the well-being of County employees by offering comprehensive benefits.

FISCAL IMPACT/FINANCING

None.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On September 17, 2002, your Board approved medical plan rates and benefit coverage changes for County and Union-sponsored medical plans for the period January 1, 2003 through December 31, 2003. Subsequently, CAPE advised us of the need to correct their point-of service (POS) medical plan offerings by adding an alternative PPO for employees residing outside California.

The PPO plan will be available only to those participants residing out of state, who are active employees or receiving continuation of their benefits through COBRA. The proposed PPO benefits are a standard Blue Shield product for out of state coverage but are different than the current CAPE benefits. However, it is important to note that premium rates remain the same as the current CAPE Blue Shield POS plan. Premium rate and benefit coverage details are shown in the attached materials supplied by CAPE.

Respectfully submitted,

DAVID E. JANSSEN
Chief Administrative Officer

MICHAEL J. HENRY
Director of Personnel

DEJ:MJH
MH:dl

Attachments (1)

c: Auditor-Controller
County Counsel

CAPE AFL-CIO
California Association of Professional Employees
Benefit Trust

December 5. 2002

Ms. Marian Hall
Employee Benefits Division
County of Los Angeles
Department of Human Resources
3333 Wilshire Blvd., 10th Floor
Los Angeles, CA 90010

RE: CAPE/Blue Shield medical coverage for out-of-state participants

Dear Ms. Hall:

As requested, enclosed is the plan summary for the PPO plan for out-of-state participants that elect a CAPE/Blue Shield plan, to be effective 1/1/03.

If you need further information, please let me know, thank you.

Sincerely,

Andrea Whalen

Andrea Whalen
Benefits Coordinator

ANNETTE M. BROWN

DEC 06 2002

1610 West Sunset Boulevard, Suite One • Los Angeles, CA 90026-3261 • (213) 484-0400 • Fax (213) 484-4963

2003 CAPE/Blue Shield
PPO for Out-of-State Participants

(800) 487-3093 www.mylifepath.com

BENEFITS	IN-NETWORK (PPO)	OUT-OF-NETWORK (Reimbursement Based on Allowable Charges)
Type of Plan	A Preferred Provider Plan	
Who is Eligible	All Participants	All Participants
Calendar Year Deductible	$250 per person; $500 per family maximum (combined In-Network and Out-of-Network)	$250 per person; $500 per family maximum (combined In-Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	After deductible, you pay a maximum of $3,000 per person; $6,000 per family (combined In-Network and Out-of-Network, copayments do not apply)	After deductible, you pay a maximum of $10,000 per person; $20,000 per family (combined In-Network and Out-of-Network, copayments do not apply)
Lifetime Maximum Benefit	$6,000,000 (combined In-Network and Out-of-Network)	$6,000,000 (combined In-Network and Out-of-Network)
PREVENTIVE CARE		
Immunizations	$25/visit (not subject to deductible)	Not covered
Periodic Health Exams	$25/visit (not subject to deductible)	Not covered
Vision Care	Not covered	Not covered
MEDICALLY NECESSARY CARE		
Ambulance	80% after deductible	80% after deductible
Doctor Office Visits	100% after $25 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	80% after $50 copayment (waived if admitted-not subject to deductible)	80% after $50 copayment (waived if admitted-not subject to deductible)
Hospital Care	80% after deductible	60% after deductible, carrier max payment $420 per day
Maternity	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
X-Ray & Lab Tests	$25/visit	60% after deductible
Prescription Drugs	$10 (generic), $15 (brand name), $30 (nonformulary-requires preapproval)	Covered for emergencies only
MENTAL HEALTH CARE		
Mental Health-Outpatient	$25/visit for non-severe psychiatric care, maximum 20 visits	Not covered
	$25/visit for severe psychiatric care	60% after deductible for severe psychiatric care
Mental Health-Inpatient	80% after $100 copayment	60% after deductible, carrier max payment $420 per day
OTHER PLAN BENEFITS		
Chiropractic Care	$25/visit, Maximum 12 combined visits per calendar year	60% after deductible, Maximum 12 combined visits per calendar year
Acupuncture Services	$25/visit, Maximum 20 combined visits per calendar year	60% after deductible, Maximum 20 combined visits per calendar year
Home Health Care	80% after deductible	80% after deductible (must be preauthorized)
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100%	Not covered unless authorized by Blue Shield
Physical Therapy	$25/visit	60% after deductible
Skilled Nursing Facility	80% after deductible (combined 100 days per calendar year)	60% after deductible (combined 100 days per calendar year)

2003 Rates:

Employee Only	$305.00
Employee + 1	$615.00
Employee + 2 or more	$797.00

Blue Shield of California
An Independent Member of the Blue Shield Association

September 17, 2002

Ms. Sandy Erickson
Dexheimer-Erickson Corporation
1149 So. Broadway
Suite B-1030
Los Angeles, California 90015

Re: CAPE – Out of Area PPO Plan

Dear Sandy:

As we discussed, the current POS Plans offered by CAPE do not provide coverage for employees who live out of state (service area). We have recently discovered that we have active employees or COBRA participants currently residing out of state

We do not want to disrupt coverage for those individuals so we will allow them to stay on the CAPE sponsored POS through the end of the year – December 31, 2002. Effective January 1, 2003 they will have to move off the plan.

To provide an alternative for these individuals, attached is a proposed PPO plan effective January 1, 2003. It would only be offered to those employees who live out of state and not any members who reside in the state of California. We are offering a PPO benefit with commensurate rates to the POS plan offering as the County system cannot handle a different set of rates other than that of the current POS plans.. Those employees can continue to stay on the PPO plan until they leave or their COBRA expires.

Please review the proposed plan and let me know if you have any questions.

Sincerely,

Carolyn H. Singer
Senior Account Manager

Cc: Denise Hammond

CAPE

$250 Deductible PPO 80/60 $25 Copay Plan
January 1, 2003

Highlights: $250 deductible, $10/$15/$30 prescription drug card

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Preferred Providers[1]	Non-Preferred Providers[1]
DEDUCTIBLES (all providers combined) Benefits marked with an asterisk (*) are NOT subject to the calendar-year medical deductible.		
• Individual	$250	
• Family	$500	
Calendar-Year Copayment Maximum Copayments for services that are marked with a # do NOT count toward the copayment maximum and continue to be charged after it is reached. Deductible does not apply toward the calendar-year maximum.		
• Individual	$3,000	$10,000
• Family	$6,000	$20,000
LIFETIME MAXIMUMS	$6,000,000	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES		
Physician services		
• Office visits and consultations	$25/visit*	40%#
• Specialist visits and consultations	$25/visit*	40%#
• Laboratory and X-rays	$25/visit	40%
• Mammogram and pap test or other FDA-approved cervical cancer screening tests	$25/visit*	40%
• Allergy testing or treatment	20%[3]	40%
• Diagnostic testing	20%	40%
Preventive care		
• Annual routine physical exam Includes: eye/ear screening, immunizations, vaccinations	$25/visit*	Not covered
• Mammogram and pap test screening or other FDA-approved cervical cancer screening tests	$25/visit*	Not covered
• Laboratory	$25/visit*	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screening, immunizations, vaccinations	$25/visit*	Not covered
• Laboratory	$25/visit	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery in hospital/facility	$50#/surgery + 20%	40%[2]
• Outpatient treatment, renal dialysis and necessary supplies	20%	40%#2
HOSPITALIZATION SERVICES		
• Inpatient visits and consultations	20%	40%[2]
• Surgeons and assistants, anesthesiologists, pathologists, radiologists	20%	40%[2]
• Semi-private room and board, medically necessary services (including subacute care) and supplies	$100/admission + 20%	40%[2]
EMERGENCY HEALTH COVERAGE		
• Facility services (waived if admitted directly to the hospital as an inpatient)	$50*# + 20%	
• Emergency room physician services	20%	20%
AMBULANCE SERVICES	20%	20%
PRESCRIPTION DRUG COVERAGE# (Including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies). Note: If the physician or member requests a brand-name drug when a generic is available, the member is responsible for the difference in cost between the brand and the generic, in addition to the generic copayment.	**Participating Pharmacy**	**Non-Participating Pharmacy** Member pays 25% of allowed charge plus a copayment of:
• Retail prescriptions (for up to a 30-day supply)	$10 Generic $15 Formulary Brand $30 Non-Formulary Brand	$10 Generic $15 Formulary Brand $30 Non-Formulary Brand
• Mail service prescriptions (for up to a 90-day supply)	$20 Generic $30 Formulary Brand $60 Non-Formulary Brand	Not covered
• Home self-administered injectable medications (may require preauthorization from Blue Shield Pharmacy Services)	30%	Not covered

Covered Services	Member Copayment	
DURABLE MEDICAL EQUIPMENT	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
• Home medical equipment, prosthetics/orthotics	20%	40%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[3]	**MHSA Participating Providers**[1]	**MHSA Non-Participating Providers**[1]
• Inpatient services	$100/admission + 20%	40%[2]
• Outpatient visits for severe mental health conditions	$25/visit*	40%*[2]
• Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits)[6]	$25/visit#	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[3]		
• Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
• Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)[6]	$25/visit#	Not covered
HOME HEALTH SERVICES (combined maximum of 100 preauthorized visits per calendar year)	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
• Home health and home infusion care (see "Outpatient Prescription Drug Coverage" for home self-administered injectables)	20%	20%[4]
HOSPICE[5]		
• Routine home care and inpatient respite care	No charge	Not covered
• 24 hour continuous home care and general inpatient care	20%	Not covered
OTHER		
Alternative care[6]		
• Chiropractic services (up to 12 visits per calendar year)	$25/visit	40%
• Acupuncture services[7] (up to 20 visits per calendar year)	$25/visit	$25/visit
Physical medicine		
• Office visits and related services (such as physical therapy and occupational therapy)	$25/visit	40%
Pregnancy and maternity		
• Prenatal and postnatal care	20%	40%
• All necessary inpatient hospital services	See "Hospitalization Services"	See "Hospitalization Services"
Family planning		
• Family planning counseling	$25/visit*	Not covered
• Elective abortion, tubal ligation, vasectomy	20%	Not covered
Skilled nursing facility (SNF) services (up to 100 days per calendar year)		
• Semi-private accommodations – freestanding SNF	20%	20%#
• Semi-private accommodations – hospital SNF unit	20%	40%[2]
Covered out-of-state benefits Benefits provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	20% or $25 copay	40%
Diabetes care		
• Equipment, devices and non-testing supplies (for testing supplies, please see "Outpatient Prescription Drug Coverage")	20%	40%
• Self-management training and education	$25/visit	40%
Optional Benefits	Optional dental, vision, inpatient substance abuse treatment, or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the mental health services administrator (MHSA) utilizing MHSA participating and MHSA non-participating providers.

2 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 40 percent of this $600 per day, plus all charges in excess of $600. For physician services, members pay 40 percent of allowable amounts, plus all charges in excess of allowable amounts.

3 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the MHSA. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Evidence of Coverage* or plan contract.

4 Out-of-network home health care and home infusion services are not covered unless they are preauthorized by Blue Shield. When these services are preauthorized, members pay 20 percent, the preferred provider level.

5 Covered hospice services received from any hospice agency must be pre-authorized by Blue Shield. If Blue Shield preauthorizes hospice services from a non-participating hospice agency, those hospice services will be reimbursed at participating hospice agency level.

6 All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

7 When members use acupuncture services performed by a preferred MD, they are responsible for the copayment. When services are obtained from a non-preferred MD or a certified acupuncturist, members are responsible for the copayment in addition to charges in excess of the allowed amount.

Benefits are subject to modification for subsequently enacted state or federal legislation.

A11968-250-f Custom (1/03)